IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2005 1182

FINDING INTO DEATH WITH INQUEST

(Amended pursuant to s76 of the *Coroners Act 2008* on 4 March 2013).

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: Stuart BEVERLEY

Delivered On:	31 January 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	7 June 2007 Final Submissions: 30 July 2010
Findings of:	Coroner Paresa Antoniadis Spanos
Representation:	Ms Julia Greenham of Counsel, instructed by Russell Kennedy, appeared on behalf of Ms Samantha Robinson Mr Paul Halley of Counsel, instructed by DLA Phillips Fox, appeared on behalf of Maroondah Hospital/Eastern Health
Police Coronial Support Unit:	Sergeant David Dimsey, assisting the Coroner

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of STUART BEVERLEY
AND having held an inquest in relation to this death on 7 June 2007 at Southbank
find that the identity of the deceased was STUART BEVERLEY
born on 23 April 1973, aged 31
and that the death occurred on or about 7 April 2005
at the rear of Bushy Creek Park Hall, Maroondah Highway, Croydon, Victoria 3136

from:

1 (a) HANGING
2 CIRRHOSIS

in the following circumstances:

INTRODUCTION & PERSONAL BACKGROUND

1. Stuart Beverley was a 31 year old man with a long history of mental illness involving self-harm and suicidality. While Mr Beverley was estranged from Samantha Robinson, his de facto partner and mother of their two children, she remained his primary carer and support, and was actively involved in his attempts to access mental health services, particularly in the period immediately preceding his death.[1]

2. According to Ms Robinson, despite Mr Beverley's long history of mental illness, he managed to obtain computer qualifications and to maintain employment until about two weeks before becoming acutely unwell/suicidal in March 2005. He was a loving father who regularly took care of his children, and was affectionately known as a gentle giant to his work colleagues. Ms Robinson's understanding of Mr Beverley's mental illness was that he had been diagnosed with anxiety and post-traumatic stress disorder after a truck accident in 1998/9, and with depression after his first involuntary admission to a psychiatric ward at Dandenong Hospital in about 1999. She was unaware of a formal diagnosis of Borderline Personality Disorder (BPD) having ever been made[2] and dated his first known suicide attempt in 1999, not earlier as

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[1] Statement Exhibit "B" and transcript page 6.

[2] Statement Exhibit "D" and transcript pages 4-5.

suggested in some hospital records. According to Ms Robinson's recollection, Mr Beverley's most recent attempt to take his life before March-April 2005 had been in late 2003, and he had been relatively stable in the ensuing period. [3]

3. On 30 March 2005,[4] a train driver observed Mr Beverley lying beside train tracks and called emergency services. First responders were officers from the MFB, who apparently found a rope fashioned into a noose hanging from a structure adjacent to the train tracks. Ambulance officers assessed him as having a Glasgow Coma Score (GCS)[5] of 10, presumably as he was initially refusing to talk to them. They saw no evident ligature marks around Mr Beverley's neck but did see multiple self-harming scars on his chest and abdomen. They conveyed him to the Maroondah Hospital Emergency Department (ED) where, after a medical clearance, he was referred for psychiatric triage/assessment.[6]

4. That assessment which was conducted by RPN Payne noted that there was no physical evidence supporting Mr Beverley's description of the attempted hanging, that he did not attend a GP, did not want ongoing Crisis Assessment and Treatment Team (CATT) support, was guaranteeing his own safety, and had future plans. The outcome was that Mr Beverley was discharged home (with provision of a taxi voucher) at about 0330hrs, and agreed to accept a phone call from psychiatric triage later that day (Thursday) by way of support. RPN Payne concluded her assessment with a recognition that Mr Beverley "Remains chronic risk of self-harm, presentation in "suicide attempts"".[7]

5. Events occurring between his discharge at about 0330hrs on 31 March 2005 and his death one week later, in particular the interactions between Mr Beverley and clinical staff from the Maroondah Hospital/Eastern Health Area Mental Health Service were the main focus of the

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[3] Transcript pages 8-10, 27.

[4] According to Ms Robinson, there had been a previous attempt a few days before this incident, involving carbon monoxide, which did not come to the attention of emergency services or the public health system, either at the time or subsequently. Transcript page 11.

[5] The GCS is a widely used score of level of consciousness, with a score of <8/15 being universally accepted as the level of coma in which a person is likely to be unable to protect their airway from saliva and other secretions, and is therefore at risk of obstruction of the airway. Patients with a GCS of <8/15 are generally thought to require intubation to protect their airway and to ensure adequate oxygenation.

[6] Exhibits "G" and "H", especially Ambulance Patient Care Record in Exhibit "G" and notes of RPN Payne's assessment dated 31 March 2005 at 0240hrs in Exhibit "H".

[7] Ibid. See also transcript pages 81 and following where there is discussion about what "Thursday" might mean in this context. A common sense reading of this note would suggest that what was envisaged was a call later that day.

inquest and will be dealt with in some detail below.[8] Suffice to say that, apart from a short admission overnight from 3 to 4 April 2005, Mr Beverley remained at large in the community, with intermittent contact with mental health services, either at his instigation or by making himself available in response to their attempts to contact and support him.

6. At about 0155hrs on 7 April 2005, police attended at the rear of Bushy Creek Park Hall, Maroondah Highway, Croydon, in response to a call made to 000 by a passer-by. Ambulance officers were already in attendance. Mr Beverley was lying deceased on his back with a white nylon rope noose around his neck. The rope had been looped around a tree branch above and was secured to the tow bar of his station wagon. A reel of the same rope was in the rear of the station wagon, while a search of the cabin revealed a computer generated diagram showing how to tie a noose, a scalpel and spare blade, two brown paper bags containing syringes, a box of diazepam apparently dispensed on 5 April 2005 (50 tablets dispensed with 16 remaining) and a note, the contents of which were consistent with an intention to take his life, folded over the steering wheel.[9]

INVESTIGATION/SOURCES OF EVIDENCE

7. This finding is based on the totality of material the product of the coronial investigation of Mr Beverley's death, that is the coronial brief compiled by Senior Constable Simon Gurr (as he then was) from Croydon Police; the statement reports and testimony of those witnesses who testified at inquest and any documents tendered through them; the statement subsequently provided by Dr Vivian Peeler, Consultant Psychiatrist, dated 15 September 2009, who was residing in England and unavailable to testify at inquest; and the written submissions of Ms Greenham on behalf of Ms Robinson, and Mr Halley on behalf of Maroondah Hospital/Eastern Health. All this material, together with the inquest transcript, will remain n the coronial file.[10] In writing this finding, I do not purport to summarise all the available material or evidence, but will refer to it only in such detail as appears to be warranted by its forensic significance and the interests of narrative clarity.

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[8] See paragraphs 15 and following below.

[9] Exhibit "C" is a series of 27 photographs of the scene taken by police on the night. The handwritten "suicide" note Exhibit "B" reads "next of kin Samantha Robinson [telephone number omitted] Police, Ambos, sorry I had to leave u to clean this up Stu Best wishes 2 u"

[10] From 1 November 2009, access to the coronial file is governed by *section 115 of the Coroners Act 2008.*

THE PURPOSE OF A CORONIAL INVESTIGATION

8. The primary purpose of a coronial investigation of a reportable death[11] is to ascertain, if possible, the identity of the deceased, how death occurred, the cause of death and the particulars needed to register the death – effectively, the date and place where the death occurred.[12] In order to distinguish *how* death occurred from the *cause* of death, the practice is to refer to the latter as the *medical* cause of death, incorporating where appropriate the *mode* or *mechanism* of death, and the former as the context, or background and surrounding circumstances in which death occurred. These circumstances must be sufficiently proximate and causally relevant to the death, and not merely circumstances which might form part of a narrative culminating in the death.[13]

9. A secondary purpose of the coronial investigation, arises from the coroner's power to report to the Attorney-General on a death; to comment on any matter connected with the death being investigated, including public health or safety or the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[14] Whilst the *Coroners Act 1985* which governs this investigation does not explicitly refer to the purpose of such reports, comments or recommendations made by a coroner, the implicit and generally accepted purpose is the prevention of similar deaths in the future.[15]

10. Finally, it is important to note that a coroner is not empowered to determine civil or criminal liability or to apportion blame, and is specifically prohibited from including in a finding or comment, any statement that a person or institution is or may be guilty of an offence. Therefore, whether or not it encompasses an inquest, a coronial investigation is best seen, not

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[11] Apart from a jurisdictional nexus with Victoria, the relevant definition of "reportable death" is in section 3 of the Coroners Act 1985 ("the Act") and includes a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury.

[12] Section 19(1) of the Act.

[13] Paraphrasing and at risk of over-simplifying the effect of the authorities – Harmsworth v *The State Coroner [1989] V.R. 989; Clancy v West (Unreported decision of Harper, J. in the Supreme Court of Victoria 18/08/1994); cf Thales Australia Ltd v The Coroners Court of Victoria & Ors [2011] VSC 133.*

[14] Sections 21(1), 19(2) and 21(2) of the Act related to such reports, comments and recommendations respectively.

[15] This is to be contrasted with the *Coroners Act 2008* which came in to operation on I November 2009 (and applies to inquests commencing after that date) and in its Preamble and Purposes (section 1(c)) explicitly refers to the coroner's role in contributing to the reduction of preventable deaths through findings and the making of recommendations.

as a trial or contest between opposing parties, but as an investigation or inquiry into facts so as to determine how the death occurred and how similar deaths may be prevented in the future.[16]

THE MEDICAL CAUSE OF DEATH

11. An autopsy was performed by Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (VIFM) who reviewed the circumstances as reported by the police and post-mortem CT scanning of the whole body. Dr Burke summarised his anatomical findings as abraded injury to the neck and fractured thyroid cartilage, consistent with hanging, cardiomegaly with no evidence of hypertrophic cardiomyopathy, and liver cirrhosis. He identified no other injuries and no other significant natural disease. Dr Burke advised that it would be reasonable to attribute the cause of Mr Beverley's death to hanging, the potential mechanism/s of death being obstruction to the airway, obstruction to the great vessels within the neck and stimulation of the carotid body, or any combination of these.[17] He further noted liver cirrhosis as a significant condition which was not directly related to the cause or mechanism of death.

12. Toxicological analysis of post-mortem samples also undertaken at VIFM, revealed no alcohol or other commonly encountered drugs or poisons, apart from diazepam and its metabolite nordiazepam, at levels consistent with normal therapeutic use. Diazepam is a sedative/hypnotic of the benzodiazepine class marked in Australia as "Antenex", "Diazemuls", "Ducene" and "Valium". The medical records tendered at inquest, verify that Mr Beverley was prescribed and taking diazepam on an "as needs" basis.[18]

FINDINGS AS TO UNCONTENTIOUS MATTERS

13. Most of the matters I am required by section 19(1) to ascertain, if possible, were uncontentious. I find as a matter of formality that Stuart Beverley, late of 10 Carroll Avenue, Croydon, born on 23 April 1973, aged 31, intentionally took his own life by hanging, on or

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[16] Several authorities grapple with the nature of a coronial investigation – for example *Harmsworth v The State Coroner of Victoria [1989] VR 989; Militano v The State Coroner (Unreported decision of Heyne, J. in the Supreme Court of Victoria 18/12/1991)* and, notably, *R v South London Coroner, ex parte Thompson [1982] 126 SJ 625 per Lane, LCJ – "An inquest is a fact-finding investigation and not a method of apportioning guilt ... the procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest, it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial – simply an attempt to establish facts."*

[17] Dr Burke was not required to attend the inquest. His detailed autopsy report which includes his formal qualifications and experience is part of Exhibit "I" the balance of the inquest brief.

[18] Exhibits "G" and "H" - notes of home visit at ~ 6 April 2005 made by CAT Clinicians Payne and Wall.

about 7 April 2005, at Bushy Creek Park Hall, Maroondah Highway, Croydon, in the State of Victoria.

"HOW DEATH OCCURRED" – THE CONTENTIOUS CIRCUMSTANCES

14. It was apparent that Ms Robinson[19] was critical of the mental health system as a whole which she believed had failed Mr Beverley over the eight years or so when she knew him and, in particular, when he was acutely unwell and desperately seeking help in the days immediately preceding his death.[20] The coronial investigation of Mr Beverley's death, including the inquest, focussed on the clinical management and care provided to Mr Beverley by Maroondah Hospital and/or the Eastern Health mental Health Program, in the week or so immediately preceding his death. Broader concerns about the prevailing paradigm of mental health service provision and the inadequate resourcing of public mental health services, are beyond the reasonable scope of a coronial investigation of Mr Beverley's death. That said, I intend neither endorsement nor criticism of the clinical management and care provided to Mr Beverley during the longitudinal course of his mental illness.

15. Although Ms Robinson may have been unaware of the diagnosis, other evidence confirms that Mr Beverley had been diagnosed with Borderline Personality Disorder (BPD)[21] from at least his admission to Dandenong Hospital as an involuntary patient in 1999.[22] Understanding the nature of this disorder and the cluster of symptoms with which Mr Beverley presented, is central to consideration of the circumstances in which he died, in particular the response of the public mental health system to his suicidality.

16. As mentioned above, in the context of a comprehensive assessment and prior to discharge from Maroondah Hospital at around 0300 hours on 31 March 2005, Mr Beverley had guaranteed his safety, refused a CATT home visit but agreed to support in the form of a

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[19] As was Ms Rita Hemmings, Mr Beverley's landlady and mother of his ex-girlfriend, who provided a statement and also testified at the inquest.

[20] Exhibit "D" and transcript page 24 and following where she articulates her particular concerns about the period from the attempted hanging on 30-31 March and Mr Beverley's death on 7 April 2005.

[21] Bipolar Personality Disorder is described in "DSM-IV-TR Diagnostic and Statistical Manual of Mental Disorders" Fourth Edition, Published by the American Psychiatric Association at pages 706-710. A more succinct description is available @ http://www.spectrumbpd.com.au - "The diagnosis of Borderline Personality Disorder is based on an assessment of symptoms over time and across a range of situations. People with BPD have a fragile sense of self and have trouble controlling their emotions, with periods of strong overwhelming feelings, including thoughts of suicide and self-harm, poor impulse control, and problems with sustaining meaningful relationships." Dr Katz also describes the disorder and the symptoms which support its diagnosis at transcript pages 57-58.

[22] Transcript page 28, 59.

telephone call from psychiatric triage the following day. During the assessment, RPN Payne noted his past history of BPD, chronic dysthymia, self harm and reported suicide attempts. The formulated discharge plan also noted that Mr Beverley did not want any psychosocial supports, did not want medication and did not attend a general practitioner.[23]

17. A number of telephone contacts then ensued, involving Mr Beverley, psychiatric triage staff and even Ms Robinson, culminating in Mr Beverley being returned by ambulance to Maroondah Hospital ED at about 1414 hours on 3 April 2005. The concern at that time was that Mr Beverley was threatening to take his own life and that of another person.[24]

18. Following referral from psychiatric triage, Dr Conor Davidson undertook a comprehensive assessment of Mr Beverley and admitted him to "West Ward", the adult inpatient psychiatric unit, as an involuntary patient pursuant to the *Mental Health Act 1986*.[25] According to the evidence of Dr Katz, Dr Davidson was a relatively junior doctor working as a hospital medical officer within the mental health program, but was not a psychiatric registrar or psychiatrist in training.[26]

19. Nevertheless, Dr Davidson's assessment documented, inter alia, that Mr Beverley –

- Had a detailed plan to decapitate himself and to kill another person;
- Could identify no obvious triggers;
- Said his mood was up an down since 1996, increasingly low in the last few weeks;
- Said he was part of a discussion group with other patients who talk about killing themselves;
- Advised that in January he had set a date for killing himself (24 April 2005) but decided to bring the date forward so as not to be close to his son's birthday;
- Identified Ms Robinson as his only social support; and,

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[23] See paragraph 4 and footnote 7 above. Also in Exhibit "H", the Clinical Risk Assessment and Risk Management form dated 31/3/05 and signed by RPN Payne.

[24] See transcript pages 14 and following for Ms Robinson's evidence about these events and Exhibit "F" pages 1-2 where Dr Paul Katz, Director of Eastern Health's Adult Mental Health Program sets out a summary based on his review of the medical records.

[25] See sections 8 & 9 of the ***Mental Health Act 1986*** – Dr Davidson was effectively undertaking the section 9 "request & recommendation."

[26] Transcript pages 62-64

- Significantly, stated he had no short term goals as he anticipated being dead and had "tidied everything up – made will etc."[27]

20. Dr Davidson's assessment concluded with a management plan for short-term benzodiazepine use, referral to the treating team to decide on the need for antidepressants or antipsychotics, possible police involvement (in light of the potential threat to another person) and admission/supervision to minimise the risk of harm.[28] Mr Beverley was nursed on level 2, that is with 15 minutely observations overnight.[29]

21. The following day, 4 April 2005, Mr Beverley was reviewed by Consultant Psychiatrist Dr Vivien Peeler, who was the Consultant Psychiatrist for the Maroondah Hospital Emergency Department at the time. Dr Peeler reviewed Mr Beverley for the purposes of the Mental Health Act 1986[30] and made a detailed note in the medical record which documented, inter alia, that Mr Beverley –

    - Was a 31 year old man with an established diagnosis of BPD;
    - Said that he had, as at January 2005, set 24 April 2005 as the date he would commit suicide, told several people of this date and in a number of recent telephone calls told CATT that he had brought the date forward to last night;
    - Had an elaborate plan to decapitate himself and to kill an ex-girlfriend by the same means,[31] but denied any current suicide plans now that the night had passed;
    - Had been on numerous medications but none had made any difference;
    - Had been chronically suicidal from the age of 11 with multiple attempts, self laceration etc.;[32] and,

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[27] Exhibit "H" contains the Assessment Form signed by Dr Conor Davidson and dated 3 April 2005. Both Ms Robinson and Dr Katz testify about the possible significance of such acts – see transcript pages 13-15 and 86 and following.

[28] See Exhibit "H" for the management plan as per the assessment proper. Also included in this exhibit is the "Admission Summary" which documents (largely) the same management plan, with the addition of linkage to support services on discharge.

[29] Exhibit "H" nursing notes @ 3 April 2005.

[30] This was effectively an examination for the purposes of section 12AC of the ***Mental Health Act 1986.*** The section provides that if the authorised psychiatrist considers that the criteria in section 8(1) do not apply – they must discharge the person from the order, or if they do apply, must confirm the order.

[31] Apparently not Ms Robinson.

[32] Although a little ambiguous, the note reads as if this is what Mr Beverley said, as opposed to history known to Dr Peeler.

- Described intense feelings of anger towards a number of people but denied any current intent to harm them.

22. Furthermore, Dr Peeler noted that Mr Beverley described unchanged dysthymia over many years, and no clear-cut depressive symptoms or psychosis. She assessed him as evasive, with euthymic affect and no perceptual disorder, intact cognition and very poor insight. Dr Peeler noted that Mr Beverley saw himself as a victim and blamed others for his situation, but displayed no delusions and no suicidal ideation. Dr Peeler conclusion/impression was that Mr Beverley was a 'man with BPD who has engineered a place of safety to deal with his hateful feelings over recent days. Situation has now resolved – albeit temporarily. No role for medications (is on none). Does not require ongoing hospitalization. Is willing and able to contact triage if required. Risk of harm to ex girlfriend has apparently resolved.'[33]

23. Following Dr Peeler's assessment, Mr Beverley's involuntary status was not confirmed, he was discharged at about 0330 hours and provided with a taxi voucher for the trip home. Some time later, he called Ms Robinson in what appeared to her to be a hysterical state, saying "the crazy bastards have let me out", or words to that effect.[34] She arranged to meet him at his home and went there in the early afternoon with their children in order to distract him. Mr Beverley told Ms Robinson that he had been given no medication, no follow-up appointments or referrals, but was able to contact psychiatric triage on an as needs basis.[35] Ms Robinson rang West Ward to complain about the situation. At inquest, she reiterated her concerns that the discharge plan was an inadequate clinical response to Mr Beverley given the severity of his presentation as she saw it at the time.[36]

24. Ms Robinson testified that later still, in the evening of 4 April 2005, Mr Beverley telephoned her at home, said he was 'in the park and felt like doing something bad to himself'. It appears that next in the sequence of events was a return telephone call from an Eastern Health clinician to Ms Robinson at about 2115 hours which concluded on the basis that she would

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[33] Exhibit "H", entry dated 4 April 2005.

[34] Exhibit "D" page 3 and transcript page 17 and following, and also pages 39-40.

[35] Exhibit "D" page 3 and transcript page 18 and following,

[36] Exhibit "D" pages 3-5 and transcript pages 20 and following, esp 24. It seems that this first contact by Ms Robinson occurred at 1400 hours on 4 April 2005.

telephone Mr Beverley to encourage him to return home and would contact psychiatric triage and/or the police if necessary. After this call, Mr Beverley did return home.[37]

25. Mr Beverley contacted psychiatric triage himself the following evening, 5 April 2005. The medical records indicate that his call was taken by "Nadia" at 2128 hours who noted that he said he was "at the end of his tether wants to talk to someone". A return call was placed by RPN Paul Casey at 2240 hours who noted Mr Beverley's recent history of contacts with psychiatric services, documented his "impression" of a man with BPD in crisis at moderate risk of suicide if left untended and his "plan" to refer to CATT. According to the concluding notation, Mr Beverley agreed not to act on any suicidal ideas, to call psychiatric triage if these ideas return and to see CATT tomorrow afternoon.[38]

26. The agreed home visit by CATT clinicians Casey and Wall took place on 6 April 2005, at 1730 hours. The clinician who wrote the notes (apparently Mr Paul Casey) knew Mr Beverley from previous professional contacts and it is apparent that the assessment is (appropriately) informed by that historical knowledge. The assessment, as documented, includes the following –

- Under "Description of Problem" – Reports 4 week history of 'subjective' mood swings with suicidal ideas and increased anger and frustration. Claims no current suicide plans or intent but still has ropes in car and unwilling to surrender these.
- Under "Client Goals" – to attend SPECTRUM[39] in order to have effective treatment for his BPD.
- Under "Mental State Examination (MSE)/General Appearance and Behaviour" – Easily engaged to speak some hostility and avoidance of accepting help.
- Under "MSE/Affect" – Angry sullen blaming "the system" for lack of help.

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[37] I have not laboured the inconsistencies and/or discrepancies in the evidence between the notes made in the medical record by the relevant clinicians (Exhibits "G" and "H") and Ms Robinson's statement (Exhibit "D") and her evidence at inquest (see transcript pages 33 and following) in relation to conversations on this date between herself and several clinicians.

[38] Exhibit "H" First Contact/Duty/Triage Form dated 5 April 2005. Some of the entries are difficult to read but it seems tolerably clear that this was the import of the notes. Although not "timed" in her statement, note the text messages sent by Mr Beverley to Ms Robinson on 5 April 2005 to the effect that "no one is going to help me, I might as well end it" at Exhibit "D" page 4 and transcript pages 39-40.

[39] SPECTRUM, the state-wide personality disorder service for Victoria is a publicly funded specialist mental health service established by the Department of Human Services in late 1998. Spectrum provides consultation, training, treatment and research in relation to people with severe and borderline personality disorder who are at risk of serious self-harm or suicide. Spectrum works closely with area mental health services and clinicians to support their work and develop their skills in providing a more effective response.

- Under "MSE/Content" – Nil delusions – Angry and preoccupied with being turned away from hospital.
- Under "Formulation/Diagnosis – 31 year old man with BPD in crisis with recent suicide ideas. Now probably attempting to return to hospital and may escalate behaviour … or in threats to kill self in order to effect admission. Reluctantly agrees to see CATT to help (1) contain crisis (2) make referral options (3) review need for medication.
- Under "Management Plan" – (1) taken on by CATT for 5 day containment; (2) Medication Review – query role for antidepressant (prophylactic); (3) Refer to appropriate long term counselling/support ie SPECTRUM or private sector or non-government organisation.[40]

27. By the time of the inquest, Dr Peeler lived overseas and Consultant Psychiatrist Dr Paul Hugo Katz, Director of the Adult Mental Health program at Eastern Health, provided a statement and attended the inquest to provide an overview of Mr Beverley's clinical management based on his consideration of the medical records.[41] Given his formal qualifications and experience,[42] Dr Katz was also able to assist the investigation of Mr Beverley's death by providing an appraisal of Dr Peeler's assessment, in particular, in the context of the nature of BPD and the prevailing paradigm of care prescribed by the Mental Health Act 1986, and by addressing the concerns raised on Ms Robinson's behalf by Ms Greenham.

28. While his statement was limited to an overview based on the medical records, in evidence Dr Katz endorsed the clinical management provided to Mr Beverley in the week or so immediately preceding his death, including in particular Dr Peeler's assessment on 4 April

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[40] Exhibit "H" contains the documentation pertaining to this home visit – entitled "Representation/After Hours & Brief Assessment Form", signed by P. Casey and N. Wall and dated 5 April 2005. At transcript page 74 Dr Katz explains what SPECTRUM is in the following terms – *"It's a state wide service that just happens to be attached to Eastern Health and a state wide service for people with a personality disorder and by and large, whilst there are ten other kinds of personality disorders, they are put on to people with borderline personality disorder and once again the emphasis is on treating the patients in the community and there's a lot of secondary consultation..."* and goes on at transcript page 75 to describe the range of programs available and the rigorous criteria for admission to the day program given the lack of beds, something like eight at any one time.

[41] Exhibit "F" and transcript pages 55-110.

[42] Dr Katz's formal qualifications and experience are detailed in his statement Exhibit "F" and include Bachelor of Medicine, Bachelor of Surgery from the University of Cape Town, South Africa, 1982; Fellowship of the College of Psychiatrists of South Africa 1990; Lecturer and Senior Lecturer in the Department of Psychiatry, University of Cape Town, South Africa 1991/1993; Fellow of the Royal Australian and New Zealand College of Psychiatrists in 1999. See also transcript pages 55-56.

2005 and her decision not to confirm the involuntary treatment order.[43] He described her assessment as reasonable and testified that –

"Once again it's based on... [the medical records] looking at them thoroughly I certainly would have concurred with her decision making process. I think it is a comprehensive assessment. She has the added advantage of having known Mr Beverley through her role as the CAT team consultant, she's actually assessed him previously, so she's got the longitudinal nature of the illness, but she's done a comprehensive assessment. She's gone through a thorough process of decision making, and made an informed decision."[44]

29. Dr Katz also concurred with the management plan formulated at the conclusion of the home visit by CAT clinicians Casey and Wall on the afternoon/evening of 6 April 2005. When asked if he thought that the management plan was reasonable he answered as follows –

"Yes certainly it would be...Mr Casey's working off a base line knowledge of Mr Beverley and once again there's a reasonably comprehensive management plan. In terms of wanting to contain the crises, look at the possible referral options so then he's put forward an involvement of the CAT for a period of at least five days, and so CAT team would remain involved by way of regular phone calls and/or home visits. Once again he hasn't closed himself off to the possibility of introducing medication; ie antidepressants into the equation, despite the longitudinal history of non-compliance with that. He's put forward a medical review which would be a review by either the medical officer or the registrar on the CAT team and/or the CAT consultant and once again a fairly extensive list of referral options, once again Spectrum, non-government organisation or private psychiatrist. So it is a comprehensive and well thought through management plan. One needs to marry that with the comprehensive assessment that was done in the inpatient unit some 20, 36 hours previously."[45]

30. It was abundantly clear and reiterated in evidence, particularly in cross-examination, that Dr Katz's appraisal of both Dr Peeler's assessment and management plan and the CAT team's assessment and management plan was very much informed by the nature of BPD, and the clinicians' need and ability to make clinical judgements in the context of the longitudinal

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[43] Transcript pages

[44] Transcript pages 71-72. At the conclusion of his evidence he maintained the reasonableness of clinical management by both Dr Peeler and the CAT team conducting the home visit on 6 April 2005 – transcript pages 104-110.

[45] Transcript pages 77-78.

course of Mr Beverley's illness. Dr Katz described the symptoms or signs which would support a diagnosis of BPD as –

> *"a pervasive pattern of instability of interpersonal relationships, self image, one's emotional being or affect, as well as marked impulsivity ... characterised by inappropriate, intense anger or difficulty controlling anger, frequent efforts to avoid abandonment or rejection, patterns of unstable and intense interpersonal relationship, characterised by alternating extremes of idealising and devaluing, identity disturbances around one's self image and sense of self, is often characterised by impulsive behaviour, whether it be sexual impulsivity, binge eating or substance misuse, further characterised by recurrent suicidal behaviour or gestures, threats of self-mutilating behaviour. There's marked instability in the mood or otherwise known as affect, chronic feelings of emptiness, and it can also be characterised by transient stress-related paranoid ideation."*[46]

31. Despite being pressed in cross-examination about alternative hypotheses, in particular that Mr Beverley was showing the symptoms of an acute depressive illness and/or major depression and that his suicidality, in terms of threats or utterances and acts of self-harm in the week or so preceding his death, should have engendered a more acute response (ideally admission to a psychiatric ward), Dr Katz maintained that it was reasonable for clinicians to have responded as they did, and to attribute the events to his BPD.[47]

32. Dr Katz's endorsement of the clinical assessments and management plans also needs to be seen in light of the paradigm of minimal necessary intervention which underlies the delivery of mental health services under the ***Mental Health Act 1986***, and the fact that current thinking is that people with BPD should generally be treated in a community setting rather than an inpatient setting.[48]

33. Following the conclusion of the inquest, in September 2009, Dr Peeler provided a statement for the purposes of the inquest. It appears that she had access to the medical records to assist her and was aware of the questions that Ms Robinson's legal representatives wished to ask her. The statement which has not been tested by cross-examination is consistent with Dr Peeler's notes in the medical records documenting her review for statutory purposes, with little material departure from those notes, except that Dr Peeler states that –

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[46] Transcript pages 57-58.

[47] Transcript pages 84 , 85, 87, 89, 92.

[48] Transcript pages 61-62, 71.

- Mr Beverley had communicated with a young woman via a 'suicide chat room' and would kill himself on 3 April 2005 as part of a pact with her;
- It was her clinical impression that Mr Beverley had become distressed by his predicament and had actively sought hospitalisation in order to prevent him from acting on the suicide pact and further murderous thoughts he had incorporated, and he agreed that he had sought hospitalisation as a place of safety on 3 April 2005 so he would not have to act on his angry and impulsive urges;
- Mr Beverley was willing to be discharged;
- The history obtained from Mr Beverley was consistent with BPD rather than a Major Depression. The rapid resolution of symptoms and impulsive nature of the initial presentation was not consistent with a Major Depressive Disorder. Neither did he display clinical signs of depression on Mental State Examination. Dr Peeler determined that there was no role for medication as he was not depressed and, furthermore, had not responded to trials of numerous medications in the past.

34. It should be noted that there is some evidence of matters known to Ms Robinson, which if conveyed to Dr Peeler, psychiatric triage or the CAT team *may* have changed their assessment of Mr Beverley's acuity and consequently *may* have changed Dr Peeler's determination not to confirm his involuntary status and/or *may* have led to a different management plan. Dr Katz conceded as much.[49] I refer to Ms Robinson's evidence at inquest that Mr Beverley's threats of suicide were significantly different from past suicide attempts in that on or about 4 April 2005, "*He'd finalised, he'd done his Will, he'd given me an envelope with spare car keys, driver's licence, all his contact details, arrangements that he wanted made for his funeral, birthday cards for the kids right up until they're 21. So I knew he was serious.*"[50] Ms Robinson did not refer to this evidence in her statement made to police on 25 May 2005. Furthermore, although she testified that she passed at least some of this information on to "Craig", one of the CAT team members, probably on the night of 4 April 2005, there is no such notation in the medical records, and such notations as there are, belie that such was her

[49] Transcript pages 67-69.

[50] Transcript page 15, 25-26, 31-33

state of mind at the time.[51] I am unable to make a finding that this information, in terms, was passed on to Eastern Health clinicians at any material time.[52]

COUNSEL'S SUBMISSIONS

35. Ms Greenham, Counsel for Ms Robinson, and Mr Halley, Counsel for Eastern Health, both provided detailed written submissions dated 20 June and 27 July, and 21 June and 30 July respectively. In summary, and without doing justice to the detail of those submissions, Ms Greenham sought adverse findings against Eastern Health on the basis of inadequate clinical response to Mr Beverley's presentations to Eastern Health in the week immediately preceding his death, a recommendation that the State Government provide more funding for SPECTRUM, and an adverse comment against Dr Peeler on the basis of her delay in providing a statement.

36. For his part, Mr Halley submitted that there was insufficient evidence to found an adverse finding against Eastern Health on the basis of Dr Peeler's failure to confirm Mr Beverley's involuntary status or the CAT team's management plan of 6 April 2005, and/or no plausible causal connection between Eastern Health's clinical management and Mr Beverley's death.

STANDARD OF PROOF

37. The standard of proof for coronial findings is the civil standard of proof on the balance of probabilities with the *Briginshaw* gloss of explication.[53] The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals or institutions involved in the clinical management or care of the deceased, unless the evidence

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[51] Exhibit "G" and "H" entry apparently written by RPN Ramadge on the morning of 4 April 2005 – *"...phone call with x partner Samantha... stated that she does not feel that Stuart is as bad as he wants the doctors to think...states that he is very moody & irritable person how [sic] likes things his way she didn't really believe that he would really kill himself as he has always called someone or made sure that there was someone around that could see him, she was not happy that he was in hospital as she felt that this would make him worse..." Also the First Contact/Duty/Triage Form dated 5 April 2005 "...Partner stating he is still homicidal/suicidal & is requesting help...[later] Samantha doesn't want me to call Stuart currently as she believes it will escalate the behaviour...Samantha is going to call Stuart & suggest he return home, if she has concerns she will contact Triage and or police..."* See also transcript pages 34 and following.

[52] I note that evidence along these lines was conveyed to Dr Davidson by Mr Beverley himself but apparently not to Dr Peeler. See paragraphs 19, 21 and 22 above and footnotes 27 and 33.

[53] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 350, 361-363: "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..."*

provides a comfortable level of satisfaction that their negligence and/or departure from the generally accepted standards of their profession, caused or contributed to the death.[54]

CONCLUSIONS

38. That Mr Beverley intentionally took his own life by hanging, is an uncontentious finding, already formally recorded above. The focus of the coronial investigation including the inquest into Mr Beverley's death was on the clinical management and care provided to him by the staff of Eastern Health in the week immediately preceding his death in response to several presentations for suicidality, concerns about threats to another and/or threatened self-harm.

39. Mindful of the applicable standard of proof and of the authorities mentioned above, I find insufficient evidence to support a finding that there was any want of clinical management and care provided by the staff of Eastern Health to Mr Beverley in the week immediately preceding his death, and/or any causal connection between such clinical management and care as was provided to him, and his death.

40. Clinicians are sometimes criticised for assessing the risk of suicide or self-harm on an episodic or cross-sectional basis, without sufficient regard to the longitudinal course of illness. In this case it is apparent that the clinical response to Mr Beverley was appropriately informed by an understanding of BPD generally and how it manifested in Mr Beverley specifically, as well as by the constraints imposed by the policy of minimal necessary intervention underlying the *Mental Health Act 1986.*

41. Apart from Ms Robinson's evidence of acts in preparation for death mentioned in paragraph 34 above, and without the benefit of hindsight, there was nothing about Mr Beverley's presentations to Eastern Health in the week immediately preceded his death which ought reasonably to have engendered a more heightened clinical response given all the known circumstances.

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[54] *Anderson v Blashki [1993] 2 V.R. 89 at 95; Secretary to the Department of Health & Community Services v Gurvich [1995] 2 V.R. 69 at 73-74; Re State Coroner; ex parte Minister for Health (2009) 261 A.L.R. 152 at [21]. As regards "causation" see March v E & MH Stramare (1991) 171 C.L.R. 506; R v Doogan; ex parte Lucas-Smith & Ors (2006) 158 A.C.T.R.. 1; Harmsworth v The State Coroner [1989] V.R. 989*

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

1.1 Borderline Personality Disorder is considered a chronic illness with an increasing body of evidence supporting improved prognosis if the patient is engaged in long-term treatment. Current thinking supports a community based self-determining approach as the optimal treatment for such patients. However, even when in treatment, it remains the case that people with BPD experience high degrees of suffering and frequent and severe distress. Between 4% - 36% of people with BPD take their own lives, and family members, carers and others can be left with feelings of grief, anger and guilt in the aftermath.[55]

1.2 Moreover, within the context of repeated and chronic suicidal thoughts and impulsive behaviours, the assessment of acute suicide risk in people with BPD, is complex and problematic. When a patient with BPD is in crisis, clinicians, as well as family members, carers and others may find themselves navigating through a set of chaotic behaviours and symptoms, which blur the boundaries of any treatment approach regarding what is and what is not safe.

2.1 In submissions made on Ms Robinson's behalf, I was urged to make an adverse finding against Dr Peeler on the basis of her failure to provide a statement until September 2009. Communication aimed at obtaining a statement from Dr Peeler and/or asking her to address specified questions formulated by Ms Robinson was between Sgt David Dimsey, as my assistant, Ms Debra Foy, then Corporate Counsel for Eastern Health and, more recently, DLA Piper (or its predecessor) as instructing solicitors for Eastern Health. Sgt Dimsey has provided me with copies of relevant written communications, and I have considered an emailed chronology dated 15 November 2012 from DLA Piper.

2.2 While it is tolerably clear that Dr Peeler was requested to provide a statement or equivalent in late 2007, and provided with a copy of the medical records for this purpose by Ms Foy in January 2008, at the latest, considerations require that Dr Peeler have an opportunity to be heard in relation to any adverse comment to be made against her.

2.3 As matters stand, I do not consider it appropriate to make an adverse comment against Dr Peeler as I am not persuaded that the coronial investigation of Mr Beverley's death was

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[55] Beatson J, Rao S, Watson C. Borderline Personality Disorder. Towards Effective Treatment. Australian Postgraduate Medicine, Melbourne, 2010.

prejudiced by the absence of Dr Peeler's statement or its late production. In the first place, Dr Katz was able to provide a clinical overview and was extensively cross-examined by Ms Greenham on Ms Robinson's behalf. Furthermore, Dr Peeler's statement dated 15 September 2009, while it provided scope for some further cross-examination about matters not previously known,[56] is unlikely to have altered the weight of the evidence or the factual matrix of circumstances in which Mr Beverley died.

3.1 Similarly, I do not consider it appropriate to make a recommendation that the State Government provide greater funding for SPECTRUM, given its wholly peripheral role here. According to the evidence before me, a possible referral to SPECTRUM was part of the management plan arrived at during the home visit by CAT clinicians on 6 April 2005, and Mr Beverley was said to be seeking such a referral and to be optimistic about the possibility, according to Ms Robinson, and distressed at the thought of rejection by SPECTRUM, according to Ms Hemmings.[57] In my view, there is insufficient connection with the death to support exercise of the coronial recommendation power as submitted.[58]

I direct that a copy of this finding be provided to the following:

Ms Samantha Robinson
Eastern Health
Senior Constable Simon Gurr (30812) c/o O.I.C. Croydon Police
Office of the Chief Psychiatrist

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: 31 January 2013

Coroners Court of Victoria

[56] See paragraph 33 above.

[57] Transcript pages 41 and 45 and following, respectively.

[58] Section 72(2) of the *Coroners Act 2008.*